		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM.	10/02/2007 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIP	LE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		09G177	B. Wi	NG_			e 2/2007
-	ROVIDER OR SUPPLIER WASHINGTON			24	EET ADDRES), CITY, STATE, ZIP CODE IS 11TH STREET, SE (ASHINGTON), DG 20019	1. <u>1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FX I	PRIVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REPERENCED TO THE APPR DEFICIENCY)	UTD BE	(XS) COMPLETION DATE
W 102	Health received via informing this office. The incident report 2007, Client #1 was unresponsive. Although the facility's nurse Emergency Medicand subsequently pronounced the client of the conditions of the facility failed to the conditions of the conditions of number views with fact administrative stail and the day programment, and the day programment observations of number views with fact administrative stail and the day programment.  NOTE: This report of the facility must be sailed that in the day for the facility must be sailed the facility must be sailed to facility and facility must be sailed to facility and facili	2007, the Department of a faxed an incident report a faxed an incident report a faxed an incident report a of Client #1 death.  It revealed that on September 9, as discovered in his bed rough attempts were made by to revive the client, the all Services (911) was notified, the Medical Examiner fent dead at the scene.  Of this incident, an on-site initiated on September 10. getive finding determined that a met federal requirements in Soverning Body and Health Care Services. The fied in this report were based on ursing care practices, and collity direct care staff, ff, medical/nursing personnel ram staff. The findings were new of clinical and medical review of the unusual incident and not be related to the client's		102		2001 0CT 17 🗁 1: 39	DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION
LABORATO	Y DIRECTORS OF PROV	NDENSUPPOER REPRESENTATIVES SIG	NATURI	E ~ ^	ππε-	<u> </u>	(X8) DATE

Any deficiency statement ending with an asterist ( ) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the statients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an a proved plan of correction is requisite to continued

		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 1 FORM A OMB NO. 0	PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A, BUI		LE CONSTRUCTION	COMPLETI	ED
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1	ROVIDER OR SUPPLIER WASHINGTON			24	IET ADDRES), CITY, STATE, ZIP CODE 9 11TH STREET, SE ASHINGTON, DC 20019		
(X4) ID PREFIX (AG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PRIMOER'S PLAN OF CORRECTI (EACH: CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
W 102	Continued From pa	ge 1	W	102			
	The governing bod operating direction safety and to preve clients assessed no	,					
W 104	that the facility's Go adequately govern would ensure its oil treatment accordin procedures.	a systemic practices revealed overning Body failed to the facility in a manner that ents' are provide with care and g to the agency's policy and	w	104		·	·
	The governing bod budget, and operat	y must exercise general policy, ing direction over the facility,					
	Based on observal review, the facility's	is not met as evidenced by: ion, staff interview and record s Governing Body failed to perating direction over the d in the following:					
	effective system of ensure ongoing nu followed agency no with the agency's p	Body failed to have an immoratoring nursing practices, rsing training and ensure nurse ursing protocol in accordance bolicy and procedures. [See 52, W368, W369, W381,			All of the agency's nurses were trained RN supervisor'on the best nursing prathe nurses will follow the agency's nurprotocol in accordance with the agency policies and procedures.  The RN has twisted the LDN and the agency policies are procedures.	actices, rsing y's	10-17-07
	2. The Governing effective system er medications to include and storage of me	Body failed to have an fective system of managing ude appropriate accounting dication as detailed in the d procedures. [See W331,			The RN has trained the LPN on the me monitoring, documentation, storage a accountability. The RN has developped to monitor the medication. The LPN with a medication pass on the weekly base consecutive months. The RN will monimedication pass on a monthly basis for consecutive months.	and d a system d monitor sis for three hitor the	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY TED
٠		09G177	8. WING _	· · · · · · · · · · · · · · · · · · ·	09/12	; //2007
	ROVIDER OR SUPPLIER WASHINGTON		2	REET ADDRESS, CITY, STATE, ZIP CODE 49 11TH STREET, SE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRIJVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		(XS) COMPLETION DATE
W 104	effective system to medication nurse procedures in acc policies and procedures and procedures and procedures. As 3.420(a)(7) PRIRIGHTS  The facility must a treatment and car	Body failed to have an ensure that the facility's followed infection control ordance with the agency's edures. [See W377] DTECTION OF CLIENTS  ensure the rights of all clients. Fility must ensure privacy during the of personal needs.		In the future the agency nursing depithat the medications are stored as perpolicies and procedures, and that the for the medication accountability in procedure to attachment #1  The former medication nurse was tended the current medication nurse was transfection control during the medication the future, the nursing department ensure that the infection control is induring the medication pass.  Refer to attachment #2	r agency re is a system lace. minated. ained on the on pass. t will	10-16-07
	Based on observations in exercise their fight (Client #2 and #3). The finding include The nurse failed to Client #3's privace During observation september 11, 20 the medication nurse to enter the nurse			It is the policy of this agency that probe respected during the medication. The medication should be given to the away from the other consumers. Eathas a designated medication area. All of the agency nurses have been the nursing best practices, Refer to attachment #3. In the future the agency will ensure is given during the medication pass.	pass. he individual ch facility trained on that privacy	10-16-07

		AND HUMAN SERVICES			•		<b>UPPROVED</b>
	OF DEFICIENCIES	& MEDICAID SERVICES	loom so		N. F. GOMETTO LOTTON	OMB NO.	
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	(X3) DATE SU COMPLET	
		09G177	B. WI	NG _		09/12	/2007
	ROVIDER OR SUPPLIER			STR	LEET ADDRESS, CITY, STATE, ZIP CODE 49 11TH STREET, SE		-
E THE OF	Washington				VASHINGT(IN, DC 20019		
(X4) ID PREFIX LAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X	PR JWIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPROEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 130	Continued From pa		W	130	•	-	
	encourage to go to the client privacy.	the medication room to allow			,		
W 149	bedroom without tu Client #3 had to ge the overhead light.	ras observed to leave the ming off the overhead light to tot of his bed and turned off	w		The mediactaion nurse was terminate implementing the nursing best practic All nurses were inserviced on best profin the future, the nursing team will e privacy is given to client #3 whenever the his bedroom.  Refer to attachment #3	tes. actices. nsure that	10-16-07
	policies and proced	evelop and implement written dures that prohibit act or abuse of the client.					
	Based on interview facility failed to estimate policies that ensure	is not met as evidenced by: s and record verification, the ablish and/or implement ad the health and safety of one lient #1) that resided in the		t			
	The findings includ	e:					
	procedures had be	o ensure policies and en developed and/or sure client's safety and to evidenced below:					
	The finding include	<b>5</b> 5.					
	medication error a	urse failed to document a nd destroy medication as ncy's nursing policy and lenced below:					
	1. During the med September 12, 200	ication administration on 07 at approximately 6:22 PM					

		AND HUMAN SERVICES . & MEDICAID SERVICES						10/02/2007 NPPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUE	TION	(X3) DATE SU COMPLET	RVEY TED
		09G177	B. WI	NG_		·	09/42	/2007
NAME OF P	ROVIDER OR SUPPLIER		-L	STR	EFT ADDRESS	CITY, STATE, ZIP CODE	03/12	12001
RGMOF	WASHINGTON			2	49 11TH STRE VASHINGTO	ET, \$E		
(X4) ID PREFIX TAĠ	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAX	1X	(EACH	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHO EFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
W 149	Client #4 dosage of bubble pack in error the pill on the shelf Through-out the respass administration leave the medication without securing the medication number of the medication number of the medication number of the ager policy and procedu Nursing staff medicationed the following staff are even medication administration administration administration of the property dispose of the staff are even medication administration	rse was observed to punch if Risperdal 1 mg form the ir. The nurse placed cup with of the computer table. mainder of the medication in the nurse was observed to on room on several occasions is dosage of medication.  If after the medication pass did se document her error and/or cation administration records to redication.  In cy's Department of Nursing are revealed that license cation error classification	<b>w</b>		are document are properly of be communic the RN. The r the policy reg consequently All agency nu The RN will the In the future will ensure the	acy policy that all medicated on the MAR, and the disposed. Additionally the ated to the designated medication nurse falled arding the medication e was terminated. It is a medication the nurses on the quant medications errors at medications errors at the policies and procedu	at medications e error must nurse and to implement error, and uartety basis. epartment re handled	
,	designated nurse y secure this pill for t Client #3, Client #4 surveyor were in the was unsecured.	communicate the error to the who was on site, to properly the safety from the the client's. I, direct care staff and the ne area when the medication noted that the nurse did not		٠	- ,			
	remove the unsect the computer table to leave the facility	ured dosage of Risperdal from and was observed to prepare.  The surveyor alerted the her departure that she had laft.	•					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	0/02/2007 PPROVED 938-0391
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION (XS)	DATE SUR COMPLETE	VEY ED
		09G177	6. WI	۱G _	· · · · · · · · · · · · · · · · · · ·	C 09/12/	2007
NAME OF P	ROVIDER OR SUPPLIER			SII	REET ADDRESS, CITY, STATE, ZIP CODE		<del></del>
RSMO	: Washington			1	49 11TH STREET, SE NASHINGTON, DC 20019		
i AG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· ID PREP TAG		PR MIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS REFERENCED TO THE APPROPRI DEFICIENCY)	BE I	(KS) COMPLETION DATE
W 149	Continued From pa	ge 5	W	149			,
	medications in according and procedu On September 12, with the designated medication administrated on Septemnurse stated "I punthrough 9/4) to conthe medication. With a medication, he away". A request documentation on	nurse failed to destroy ordance with the agency's re as evidenced below:  2007 at 8:15 PM, interview of the stration records revealed that at 2 mg medication was ber 4, 2007. The Designated ched out the 4 dosages (9/1 respond with the start date of then asked how he destroyed commented "I threw them was made to see the file for the medication disposal e was unable to provide our missing pills.		•	The designated nurse and medication nurse trained by the RN on a quarterly basis; training will focus on on the policies and pregarding the nurses best practices. In the future the designated nurse will ensthat the medications are disposed according the agency's policies and procedures, and a proper documentation is available to show evidence.	this procedures sure ing to I that	
	Client #3 prescribe in accordance with procedure as evidence of the prescribed of the procedure of the prescribed of the prescribed of the procedure of the prescribed of the pre	tion administration on 17 at 7:25 PM, the nurse failed at #3's Ketoconazole Cream 2% rea, Minerin Cream for the esonide 0.05% Cream for the by the primary care physician. Cation nurse revealed that she nished with the medication as to have receive these topical the evening medication pass.			It is the policy of this agency that all mediare administrated as prescribed. The curmedication nurse was inserviced by the denurse.  The RN will train the nurses on a quartery or as needed.  The designated nurse will review, and mothe medication administration on a weekled for 3 consecutive months. The RN will mothe medication pass on a monthly basis for consecutive months.  Refer to attachment #1  In the future the agency's nursing depart will ensure that the medications are admit as prescribed.  According to the agency's policies and pro-	rent lesignated 10 y basis conitor ly basis onitor or three tment lnistrated	-16-07 10-16-07
FORM STATE OF	preventative care medical condition	in accordance with Client #1's			the nurse needs to document, and report significant event related to the individual! health and safety. The medication nurse	tany 's	,

PRINTED: 10/02/2007

		AND HUMAN SERVICES			•	FORM A	VPPROVED
	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUA	Torrito		PLE CONSTRUCTION	OMB NO.	
	CORRECTION	IDENTIFICATION NUMBER:	A BUI			(X3) DATE SU COMPLET	red
Lu		09G177	B. Wit	NG		09/12	; У <b>200</b> 7
NAME OF PE	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, SYATE, ZIP CODE		
RGMOF	WASHINGTON				19 11TH STREET, SE /ASHINGTON, DC 20019		
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W: 149	Continued From pa	age 6	W	149	In the future the nursing department that the nurses will report significant $\epsilon$	will ensure event related	1
	5. The facility's nu	rsing staff failed to ensure			to the individual's health and safety.		
	implemented. (See	licy and procedures were			Refer to W 104 (3) P.3	1	0-16-07
W 159	6. The facility's dir agency's policy an medical personnel 483.430(a) QUALI RETARDATION P	ect care staff follow the d procedures of notification of (See W192) FIED MENTAL ROFESSIONAL	<b>W</b>		All staff were trained on the signs and possible son March 2, 2007. All staff is retrained on signs and symptoms of proper notification of the medical personner in the future the the agency will ensure the future the the significance in the individual's health stat Refer to attachment #5	were illness and sonnel. ire that the ne there a	10-09-07
	integrated, coordin	e treatment program must be lated and monitored by a tardation professional.					
	Based on interview facility's Qualified Professional (QMI	is not met as evidenced by: v and record review, the Mental Retardation RP) failed to adequately and coordinate each client's					
	The finding include	es:					
V∉ 192	to implementation procedures of not for Client #1. [See	to ensure that staff were trained the agencies policies and fication of medical personnel W192] AFF TRAINING PROGRAM		192			
·	For employees wi must focus on ski toward clients' her	no work with clients, training ils and competencies directed alth needs.					
	Based on observa	is not met as evidenced by: ation, staff interview and record failed to effectively train staff to					

		AND HUMAN SERVICES				FORM A	10/02/2007 PPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A		PLE CONSTRUCTION G	OMB NO. (XX) DAYE SUI	RVEY
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NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
RCMO	F WASHINGTON				49 11TH STREET, SE YASHINGT()N, DG 20019		
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111100	Continued From pa	ige 7	w	192			
! 	implementation its	policies and procedures of cal personnel for one of the he facility. (Client #1)	••			·	
	The findings includ	e:					
	implemented the a procedures to ensumedical profession On September 12, with Staff #1 reveaduring the 3:00 PM	d to ensure direct care staff gency's policies and ure direct care staff notified als as evidenced below:  2007 at 10:10 AM, interview led that on September 8, 2007, 1 - 11:00 PM shift, the staff Client #1 health status as			All staff were trained on the signs and on illness on March 2, 2007. All staff retrained on signs and symptoms of proper notification of the medical per In the future the the agency will ensustaff notify the medical personnel in the change in the individual's health strefer to attach #5	were Illness and sonnel. Ire that the he there is	10-09-07
	6:30 PM Client #1 self and was obse	ived for duty between 6:00 - was observed to be his "normal erved sitting in the medication he medication nurse.			,		
	#1 observed Client stairwell and walk Reportedly this wa meal time. Staff # "loved to eat and to behavior," Staff #	:30 PM (one hour later), Staff I #1's to come down the over to dinner table very slowly. s not usually behavior during #1 explained that the client his was not his normal 1 stated that Client #1 set down					
	then immediately to mouth and placed dinner table. The intensity to the sur client left the table #1 did not notify no the client's refusal						
	According to an in	terview with the Residential					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTED:	10/02/2007
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				FORM. OMB NO.	APPROVED 0938-0391
AND FLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA - IDENTIFICATION NUMBER:		ALL TIP	PLE CONSTRUCTION	(X3) DATE SU COMPLE	URVEY
		09G177	B. WII	NG			C
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		1 8701	EET ADDRES ), CITY, STATE, ZIP CODE	09/1	2/2007
RCMO	F WASHINGTON	•		24	IS 11TH STREET, SE IASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEHCIENCY	N'EMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PRIVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEPICIENCY)	MILDRE	(XS) COMPLETION DATE
VV 192	record verification, and symptom of ilin	at 11:40 AM and training Staff #1 was trained in signs less on March 2, 2007.	W	192			
	went into Client #1's sitting on the side of and forth. She comvery heavily." Staff bath and he refused the client 8 ounce of to return to bed. Staff had been to a common three days ag to have similar symwith the staff and the provide evidence the staff had been notification.	y, 9:00 PM on 9/8/07, Staff #1 s bedroom and observed him of his bed quitely rocking back omented, "He was sweating if #1 asked the client to take a d. At that time the staff gave of water and encouraged him taff #1 reported that Client #1 munity hospital's emergency to (9/5/07) and was observed ptoms at that time. Interview he review of records failed to the nursing or management by of the client's health status.		-	Refer to W 192 P. 8	10	-09-07
	read: "TO: ALL RC!  nurse if any residen	2007 a note was observed in the medication room that M STAFF - Please notify the it is not feeling well, so that luated and treated."			Refer to W 192 P. 8	10	-09-07
W 318	and symptoms of ill and signature sheet listed as a participal 483.460 HEALTH C	CARE SERVICES	W	318	Refer to W 192 P. 8	10	1-09-07
	The facility must en services requirement	sure that specific health care nts are met.					
	This CONDITION in The facility failed to	is not met as evidenced by: provide adequate Health Care					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					10/02/2007
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. GUI		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY TÉD
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDREES, CITY, STATE, ZIP CODE	<u>J varı</u>	<u>2/2007</u>
RCMO	WASHINGTON			2	249 11TH STREET, SE WASHINGTON, DC 20019		
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPL DEFICIENCY)	MII D BE	(XS) GOMPLETION DATE
W 318	Continued From pa	de 9	w:	240			<del> </del>
	Services as evidenthroughout this rep	ce in the deficiencles cited	***	<b>5</b>   0			
	reviewed, the facilit failed to ensure hea	on, interviews, and record y failed to establish systems to alth services were provided to			Refer to W 322 (1,2,3) P. 11&12	•	10-16-07
	meet the needs of facility failed to prove and identify service	the clients [See W322]; the vide health care monitoring as that would ensure nursing			Refer to W 322 (1,2) P. 11 The RN has trained the LPN and med		10-16-07
	services were provineeds [See W331]; that each client's manner reviewed by the photoe facility falled to systems that ensur medication records facility falled to have drug administration	Ided in accordance with clients the facility falled to ensure redication regimen was armacist quarterly [See W362]; establish and maintain a es that an individuals were maintalned [W365]; the an organized system for [W367]; the facility failed to			nurse on the medication monitoring, documentation and the importance of the vital signs and weight.  Refer to attachment #6 (a)  In the future the nursing supervisor with the physicians orders are implementations.  All nurses were trained on the medical	f taking will ensure nented as	10-16-07
	accordance with phenoise accordance with phenoise facility falled to ensure administered prescience [W369]; the facility administration error facility falled to ensure proper conditions of security falled to store conditions of security falled to secu	itions were administered in hysician's orders [W368]; the ure that medication nurse without error failed to ensure that drug is were recorded [W375]; the ure medication were stored tions of sanitation [W377]; the edrugs under proper ity [W381]; the facility failed to			Imonitoring, documentation and according the future the agency nursing dep will ensure that the medications are administered according to the agency and procedures. If Refer to attachment #1  The facility nurse as well as all of the nurses were trained on the document A release of responsibility form will be	ountability, artmant are 's policy agency's tation, e comoleted	10-16-07 10-16-07
W 422	when not being pre [W382].  The results of these the demonstrated f health care service 483.460(a)(3) PHY	biologicals locked securely pared for administration  systemic practices results in allure of the facility to provide s.  SICIAN SERVICES	W	322	accurately each time the individual k	eaves the	

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		& MEDICAID SERVICES				NPPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MU A. BUIL	LTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	RVEY TED
		09G177	B. WING	3	09/12	) 2/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESH, CITY, STATE, ZIP C		
RGMO	Washington		.	249 11TH STRIET, SE WASHINGTON, DC 20019		
(/v+) ILL FREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROMDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-LEFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
· W 322	Continued From pa	ge 10	W 3	22	·	
	Based on interview	is not met as evidenced by: and record review, the facility neral and preventive care.				
1	The finding include	s:				Į
	provided for Client accordance with the procedures as evident.  1. Interview with the at 5:40 PM revealed on 9/8/07 and note "swollen and tight" notes dated 9/8/07 records failed to in	ne medication nurse on 9/10/07 ed that she assessed Client #1 ed that both his legs were . Although the nursing progress ' verified her assessment, the idicate that the client's swollen		According to the agency's policithe nurse needs to document, significant event related to the health and safety. The medicat terminated for failing to following and procedures.  All nurses were trained on the practices.  In the future the nursing depait that the nurses will report sign to the individual's health and so the individual's health and so the practices.	and report any Individual's ion nurse was ng the policies nursing best rtment will ensure ificant event relate afety.	10-16-07
	9/11/07 at approxithe nurse spoke witelephone contact #1 was not feeling the doctor asked swollen. The nurse	he day program nurse on mately 2:15 PM revealed that if the Client #1's PCP via a on 9/4/07 to report that Client well. According to the nurse he nurse was the client's legs are informed the PCP that the not swollen at that time.		Refer to W 322 (1) P. 11		0-16-07
	physician on 9/19, the physician was legs. She indicate been exhibiting si	terview with the primary care 107 at 11:20 AM revealed that aware of the Client's swollened that the Client may have gns of heart disease.  about the facility's emergency		Refer to W 322 (1,2) P. 11	,	10-16-07

		& MEDICAID SERVICES			ı	FORM A	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
	<u></u>	09G177	B. Wil	NB_		1	2/2007
	ROVIDER OR SUPPLIER F WASHINGTON	•		2	REET ADDRESS, CITY, STATE. ZIP CODE 49 11TH STREET, SE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG	×	PRC VIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-F.BFERENCED TO THE APP DEFICIENCY)	DULD BE	(XS) COMPLETION DATE
W 322	notification protoco knowledgeable and the designated number during any health reduring a medical er Review of the agent personnel policy and assessments outling to "communicate a Director, QMRP and immediately". The to her supervisor of Client #1's condition assessment on 9/8 483,460(c) NURSII The facility must preservices in accordance of the protocol of the facility for the facility facility is services in accordance of the protocol of the facility is services in accordance of the facility is serviced in the fac	istated that the policy required is to contact her directly selated concern especially nergency.  cy's notification of medical diprocedures for nursing es that the nursing staff ware my concerns to the Medical diexecutive Program Director nurse failed to communicate in the Medical Director that in had change after her low services with nursing since with their needs.  s not met as evidenced by: ion, interview and record ailed to provide nursing since with the needs of the his facility. (Clients #3).		322	Refer to W 322 (1,2) P. 11	1	0-16-07
	Interview and record records on Septem 1:00 PM revealed to orders for vital sign at 7:00 PM monthly Further review of tithe nurse was to he the medication passes to documented as	d review of Client #3's medical ber 11, 2007 at approximately hat the client has physician is and weight were to be taken and document in the MAR. He MAR revealed that 9/11/07 have taken the vital sign during is. Additionally, the nurse had by vital signs from the period of motion of the period of the review			The RN has trained the LPN and me nurse on the medication monitoring, documentation and the importance of the vital signs and weight. In the future the nursing supervisor that the physicians orders are implended to attachment #6 (a)	of taking will ensure	10-16-07

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		AND HUMAN SERVICES & MEDICAID SERVICES					10/02/2007 NPPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY ED
	1	. 09G177	B. WII	NG		09/12	/2007
	ROVIDER OR SUPPLIER WASHINGTON			24	EET ADDRESS, CITY, STATE, ZIP CODE 49 11TH STREET, SE /ASHINGTON, DC 20019		
CH (CK) Xi-12.44 DA <sup>2</sup>	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		FRI MIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEPICIENCY)	JLD BE 1	(X5) COMPLETION DATE
1 1 351	review of the weigh	ige 12 cordered. According to the at charts in the MAR the last ent #3's weight was in April	. W	331		,	
W 362	483.460(j)(1) DRU	3 REGIMEN REVIEW Input from the interdisciplinary the drug regimen of each client	W	362			,
	Based on staff inter facility failed to en- medication regime	is not met as evidenced by: eview and record review, the sure that each client's n was reviewed by the rly, for one of the four client lity. (Client #1)					
	records revealed to pharmacological re	nurse and review of the medical hat Client #1 last eview occurred on March 19. to the nurse, the next review			The last pharmacy review for client # completed on 6-25-07. Refer to attachment #7	†1 was	
W 365	the drug regimen in that the Pharmaci medications for the not occurred timel regulations.	death investigation, review of review sheet failed to evidence st reviewed Client #1 e next quarter June 2007 had y as required by this	w	365			
	An Individual med must be maintained	ication administration record ed for each client	·				
	This STANDARD	is not met as evidenced by:				•	

STATEMENT AND PLAN C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G177  NAME: OF PROVIDER OR SUPPLIER  STREET		R/CLIA MBER:	(X2) MULT A. BUILDI B. WING			URVEY ETED C 2/2007
	ROVIDER OR SUPPLIER		249 11TH	DRESS, CITY, STREET, S STON, DC	STATE, ZIP CCDE SE 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	CID I	ID PREFIX TAG	PRIMIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
1 000	Via fax Incident report Client #1 that occur the group home in various September 10, 200 2007. The licensur report were based a medication nurse, I care staff, manage review of medical review of medical review.	2007, this office was ort regarding the dea red on September 9 which he resided.  ation was initiated on 7 through Septembe e deficiencies cited if on observation of the interviews with facility ment and day prograss well a review of the seconds and review of the seconds.	th of , 2007 in r 12, n this r direct m staff,	1000			,
i 202	description, which o	EL POLICIES  hall have a written jo letails each of his or duties and supervise	her major	1202			
	have on file for reviall employees.  The finding include Review of the persi	met as evidenced by view, the GHMRP fa ew current job descri s: prinel files on Septen vealed the GHMRP (	iled to iptions for		The Pm medication nurse was to The Designated nurse's job des	erminated cription is	9-25-07
l 206	provide current job Medication Nurse a assigned to this fac 3509.6 PERSONNI	descriptions for the I and the Designated N ility. EL POLICIES	PM lurse	1 206	currently on file. Refer to attachment #11 In the future tha provider will e employees job descriptiona are	nsure that all of on file.	9-25-07
lealth Regula	ation Administration	or to employment an	d		TITLE	<del></del>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE STATE FORM

6V2111

(XS) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDENSUPPLIENCIA DENTIFICATION NUMBER:  09G177		R/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION  G	(XS) DATE SURVEY COMPLETED C 09/12/2007		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	ADDRESS, CITY, STATE, ZIP CCIDE		1 00/11	75441
RCMOF	WASHINGTON		249 11TH WASHING	STREET, S STON, DC 2	E . 0019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Eta i	ID PREFIX TAG	PRIVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	DULD BE	(XS) COMPLETE DATE
l 206	certification that a liperformed and that	age 1 , shall provide a phys nealth inventory has t t the employee's he her to perform the re	been alth status	l 206	•		-
	Based on interview GHMRP failed to e prior to employment provided evidence that documented a performed and that	met as evidenced by and record review, to an annually there of a physician's certifulation the employee's health inventory had the employee's health for the perform their theses:	he loyee, . after, fication been Ith status				
l 222	Professional and measonnel files on a PM revealed the G	Qualified Mental Reta eview of the GHMRP September 12, 2007 iHMRP failed to provi ent health certificates	's at 1:10 ide	1222	Staff # 1 health certificate was on f corporate office; however she was to on 10-03-07. Refer to attachment #12 In the future tha agency will ensure the staff personal files are present in and available upon request.	erminated that all of	9-25-07
Health Regul	This Statute is not Based on observational verification, the Gloon were conducted for the findings includation Administration	-	sonnel. y: ecord				

8V2111

D PLAN (	T OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NO 09G177	ER/CLIA JMBER:	(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION .	(X3) DATE SI COMPLE	TED
CE OF P	ROVIDER OR SUPPLIER		STREET AL	DRESS, CITY	STATE, ZIP CI DE		21 <u>20</u> 01
C M O	WASHINGTON		249 11TH WASHIN	I STREET. !	STREET, SE FON, DC 20019		
(X4) ID REFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED BY BC IDENTIFYING INFORM	V E1 11 1	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLE DATE
1 222	implemented the a	age 2 d to ensure direct ca gency's policies and ure direct care staff i		1 222			
	On September 12, with Staff #1 reveal during the 3:00 PM noted changes in C described below:	als as evidenced be 2007 at 10:10 AM, i led that on Septemb 1 ~ 11:00 PM shift, tr Client #1 health statu	nterview er 8, 2007, e staff is as				
normal self" and we medication room to nurse.  At approximately 7 #1 observed Client stairwell and walk Reportedly this was meal time. Staff # "loved to eat and to behavior." Staff # at the table and to then immediately to mouth and placed dinner table. The intensity to the surcilent left the table #1 did not notify nuther client's refusal		was observed to be vas observed sitting alking with the medic all PM (one hour late #1's to come down over to dinner table vas not usually behavious was not his normalis was nor	in the ation ter), Staff the year slowly. Or during client		All staff were trained on the sof illness on March 2, 2007. A by the designated nurse on the illness, and proper notifical	All staff were retrained the signs and symmoor	۱.
		stated that Client # k one bit of his dinn bok the bite of food f the un chewed food staff commented with yeyor, "He was sick!" without eating his m reing or management	1 set down er. He rom his on the 1 great ' The		health status changes. Refer to attachment # 5 In the future tha agency will a notify the nursing or manage client health status changes.	ensure that the chaff	10-09-0
	record verification, and symptom of ilin	erview with the Resi at 11:40 AM and tra Staff #1 was trained less on March 2, 20	aining 1 in signs 07.				
	2. At approximately	v. 9:00 PM on 9/8/07	Oto##4	1	1		l

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER:  09G177  IAME OF PROVIDER OR SUPPLIER		ER/GLIA JMBER:	B. WING VS) MUL	TIPLE CONSTRUCTION NG		TED ; `	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY	STATE, ZIP CODE		2/2007
	F WASHINGTON	<u> </u>	249 11TH WASHING	STREET.	SE ·		
(M4) ID PREFIX TAG	REGULATORY OR I	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED BY SCIDENTIFYING INFORM	/ man	ID PREFIX TAG	PRC VIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-F.EFERENCED TO THE DEFICIENCY)	1 6HOH# 0 BC	(X5) COMPLETE DATE
l 222	went into Client #1' sitting on the side of and forth. She convery heavily." State the client 8 ounce of to return to bed. Si had been to a common three days ago to have similar symwith the staff and the provide evidence the staff had been notificated on the wall read: "TO: ALL RC nurse if any resider	age 3 's bedroom and obset of his bed quitely roc nmented, "He was so if #1 asked the client d. At that time the s of water and encours taff #1 reported that munity hospital's em go (9/5/07) and was o intoms at that time. he review of records hat the nursing or ma if of the client's healt 2007 a note was obseint he medication roc M STAFF - Please n of is not feeling well, luated and treated."	king back weating to take a taff gave uged him Client #1 ergency observed interview failed to unagement the status.	1222		-	
	signs and symptom agenda and signati #1 was listed as a p	cy training log revea ill staff were trained on so of illness. Review are sheet revealed the participant in that trai	of the		All staff were trained on the signs of illness on March 2, 2007. All signs the designated nurse on the sof illness, and proper notification health status changes.  Refer to attachment # 5	aff were retrained	10-09-07 5
	3510.5(d) STAFF T Each training progra limited to, the follow	am shall include but	1		In the future tha agency will enso notify the nursing or manageme client health status changes.	ure that the staff nt when the	. '
	(c) Infection control This Statute is not grassed on interview	for staff and residen met as evidenced by and record review, to ave on file training for infection control		·	Refer to W 149 P,7	. 10-	16-07

	r of deficiencies of correction	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER 177		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 09/12/2007
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
RCMO	WASHINGTON			STREET, SE TON, DC 20		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PRIMIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
1 227	Continued From pa	age 4		1 227		
	See Federal Defici	ency Report Citation	W377	j		
1 370	3519.1 EMERGEN	ICIES		I <b>37</b> 0		
	procedures which including fire or ge	ill maintain written pol address emergency s neral disaster, missin lness or trauma, and	situations,			
	This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP falled to ensure that the staff and nursing personnel followed the agency policies and procedures on emergencies.					
[	The finding include	e:				
	See Federal Defic W318	iency Report Citation	W104,		Refer to W 104 P.3 Refer to W 318 (1,2,3) P.11	10-16-07 10-16-07
						. •
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			·			
Health Regi	ulation <b>Admi</b> ntstration RM			EROS	***************************************	<del></del>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTED:	10/02/2007
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		09G177	B. WI	NG_			2
NAME OF P	ROVIDER OR SUPPLIER		<u></u>	e-	REET ADDRESS. CITY, STATE, ZIP CODE	09/12	2/2007
	WASHINGTON				249 11TH STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PRCVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-PEFERENCED TO THE APP DEFICIENCY)	SULD BE	(X5) COMPLETION DATE
W 365	Based on staff inter facility failed to esta that ensures that ar records were maint clients that are entrand #4)	view and record reviews, the blish and maintain a systems individuals medication ained for two of the four usted to the facility. (Client #3	W	365	,		
	documentation of Cladministration in ac policy and procedur following:  Review of Client #3 Record (MAR) after observation on Sep approximately 6:15 the client's noon do had not been signe	The facility failed to ensure its system for documentation of Client #3's medication administration in accordance with the agency's solicy and procedures as evidence by the collowing:  Review of Client #3's Medication Administration Record (MAR) after the medication pass abservation on September 11, 2007 at approximately 6:15 PM revealed that on 9/8/07 he client's noon dosage of Hydroxyzine 25 mg and not been signed as being administered.			All nurses were trained on the medic monitoring, documentation and aco In the future the agency nursing dep will ensure that the medications are administered according to the agenc and procedures. Refer to attachment #6 (b)	ountability. Partment	10-16-07
·	approximately 11:4 weekend nurse fail was administered. bubble packed evid	esignated nurse on 9/12/07 at 5 AM revealed that the sed to sign that the medication Review of the medication lence no pill in the slot moon dosage for 9/8/07.					
-	administration of C	d to ensure its system for Client #4's medication coordance with the agency's res as evidence by the					
	Record (MAR) after observation on Sep	's Medication Administration r the medication pass tember 11, 2007 at PM revealed that on 9/8/07			The facility nurse as well as all of the nurses were trained on the documer A release of responsibility form will be accurately each time the individual in	itation, e completed	10-16-07

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2007 FORM APPROVED OMB NO. 0938-0391

AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(XII) DATE S COMPLE	
		09G177	B. WING	<del></del>		c
NAME OF P	ROVIDER OR SUPPLIER	330171	<del></del>	REET ADDRESS, CITY, STATE, ZIP CODE	09/1	2/2007
K 6 IVI O	F WASHINGTON	,	2	MASHINGTON, DC 20019		
(X4) ID PROFIX	CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID .	PROVIDER'S PLAN OF CORRECT	ION	Des)
TAG	REGULATORY DR LE	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACI CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	II IN SIG	COMPLETION DATE
. W 362	-ourseast tour bei		W 365			-
	the client's noon do not been signed as	sage of Buspirone 10 mg had being administered.	555			
	weekend nurse faile was administered, bubble packed for the	esignated nurse on 9/12/07 at 5 AM revealed that the ed to sign that the medication Review of the medication nat date evidence no pill in the				
	Review of the medicabsence form for 9/ that Client #4's motion to pick him up until	the noon dosage for 9/8/07.  Cal record indicated a Leave of 8/07, however staff indicated the facility after 5:00 PM in the evening		Refer to W 365 P. (1) P.	. 10	<b>)-16-0</b> 7
	form for Client #4's medication to admir	se failed to sign, date and e release of responsibility mother who was given his istered during his home visit.		,		
	the bubble pack to	idence that the facility had an order of the facility had an order order of the facility had an order of the facility had an order o				
	Client #4's Risperda bubble pack into a patterwards commen medication". She we cup with the pill on the nurse was observable pack of pills. The nurse punch ou administered the medication of the nurse punch ou administered the medication with the nurse punch ou administered the medication with the nurse punch ou administered the medication with the nurse punch our administered the medication with the nurse punch our administered the medication with the nurse punch our administered the nurse punch our page 12 miles and 12	at approximately 6:15 PM edication nurse punched of 11 mg medication from the paper cup and immediately ager to place the he side of the computer table. And the medication closes to the second pill and then adication to Client #4. Review a packaging revealed that the		All the agency nurses were trained on t medication administration utilizing the pack to ensure the accuracy, and accor- of medications. All discontinued medic- will be removed from the cabinet assoc- possible. Refer to attachment #8 In the future the agency's nursing depa will ensure that the drug administration bubble pack is utilized effectively, and to discontinued meds are removed promp	bubble untability ations on as artment using the	10-16-07

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					PRINTED:	10/02/2007
CENTER	S FOR MEDICARE	& MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391	
STATEMENT AND THAN D	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRU G	NOITC	(XX) DATE SU COMPLE	RVEY
		09G177	B. Wi	NG_				S Stanna
NAMEOFP	ROVIDER OR SUPPLIER			STE	PET ADORESS	, CITY, STATE, ZIP CODE	usri	2/2007
RCMO	WASHINGTON			2	49 11TH STRE			
(X4) ID PREFIX 'FAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx.	PRC (EACH	VIDER'S PLAN OF CORRECTORECTIVE ACTION SHO EFERENCED TO THE APPI DEFICIENCY)	iiibar .	(X5) COMPLETION DATE
W 365	Continued From pa	ge 15	W	365				
	that the nurse was i Risperdal 1 mg dos	resignated nurse revealed that not to have punched the age and commented, "This deen removed from the				,		
	revealed the Risper discontinued on 9/5 dosages for 9/5, 9/6 missing from the bu	cation Administration records dal 1 mg dosage had been dal 7 mg dosage dal 8 mg dosage dal 8 mg dosage dal 9 mg dos			Refer to W	365 P. 15 (3)	1	0-16-07
	September 11, 200 revealed that the m	he medication pass on 7 at approximately 6:16 PM edication nurse punched al 2 mg medication from the			-			
	This dosage of med The Designated Nu dosage for 9/1, 9/2, date on the bubble with the physician of surveyor requested used in documenting dosages of Risperd was unable to prod	designated nurse revealed that ication was started on 9/5/07. Irse stated "I punched out the 9/3 and 9/4 so that the start packaging would correspond ordered start date." The to see the agency Drug forming the disposal of the four lail. The Designated Nurse luce any documentation ling the missing Rispordal			Refer to W 3	, 365 P. 15 (3)		D-16-07
W 368	9/12/07 failed to evi document the dispo Risperdal pills.	and the nurses notes on idence that the nurse had osal of the four missing G ADMINISTRATION	w;	368			•	·

	10/0	2/2007	04:40	FAX	2024429	430
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		& MEDICAID SERVICES					PPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
	·	09G177	B. WI			09/12	; /2007
	ROVIDER OR SUPPLIER  WASHINGTON			2	CET ADDRESS, CITY, STATE, ZIP CODE 49 11TH STREET, SE /ASHINGT(N), DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PR NODER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 368	Continued From pa	ge 16	W	368			
	The system for drugthat all drugs are action the physician's order	g administration must assure Iministered in compliance with ers.	•				
	Based on observation review, the facility formedications were a	s not met as evidenced by: lon, interview and record alled to ensure that administered in accordance lers for one of clients who by. (Clients #3)		,			
,	The finding include	s:					
	medications prescr	ation nurse failed administer ibed by the primary care ance with the agency's policy		•			
	The finding include	s:					
	September 12, 200 The medication nu	medication administration on 17 at approximately 7:52 PM, rse was observed to remove in cabinet four topical					
	2007 revealed that	iclan's order dated August 1. Client #3 was to have received I treatment during the evening		-			
	area of beard BID  2) Laprox Shampo  3) Lachydron 12%  the leg BID	% Solution Apply to affected to to scalp 2 X week Lotton Apply to scaly areas of cream Apply to affected area			Refer to W 149 (3) P. 6 Refer to attachment #6	10	-16-07
L	<u> </u>						

DEPART	MENT OF HEALTH	AND HUMAN SERVICES  A MEDICAID SERVICES				FORM	10/02/2007 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			COMPLE	
		09G177	B. WING			1	C
!	ROVIDER OR SUPPLIER		<del></del> -	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 09/1	2/2007
RGMO	F WASHINGTON				49 11TH STREET, SE VASHINGTON, DC 20019		
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PRCVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-FEFERENCED TO THE APPR DEFICIENCY)	ULD BF	COMPLETION DATE
W 368	Continued From pa of face BID	ige 17	W	368			
	the ear and neck at was applied to both pass. After applyin	1) Erythromycin 2% cream to nd the (2) Amiactin 12 % lotion in lege during the medication at this medication, she stated laced all 4 medication back in set.					
	however, revealed	t for September 2007, I that Client #3's topical ons for administration were as					
	area twice daily   2) Minerin Cream :   moisturizer	cream 2% apply to affected apply daily to skin for Cream Apply to dry area of		,			
W 250	MAR and the medinurse did not coinc administered the A the med pass, how list on the physiciar Ketoconazole Crea administered twice MAR revealed that indicated that this radministered during ordered. 3. The Mi Cream which was been administered pass as ordered.	ted on the physician order, the cation administered by the cation administered by the cation administered by the cation administered by the cation 12% solution during ever this medication was not norder. 2. Client #3's m 2% was to have been daily, however review of the for the month of September medication was not being stently and was not g the medication pass as inenn Cream and the Desonide prescribed for the PM had not either during the medication			Refer to W 149 (3) P. 6 Refer attachment #6 (b)	10	0-16-07
W 369	483.460(k)(2) DRU	G ADMINISTRATION	w:	369		٠	
				'	L		1

10/09	/9007	04:40	TAY	2024	190190
1.0/02	/ 2001	04,40	LVV	2024	<b>4</b>

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		I AND HUMAN SERVICES  & MEDICAID SERVICES		•	Ī	FORM	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		09G177	B, WI	IG			C 2/2007
	ROVIDER OR SUPPLIER WASHINGTON			24	EET ADDRESS, CITY, STATE, ZIP CODE 49 11TH STREET, SE VASHINGT(IN, DC 20019	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(XA) ID DREETY TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PR JVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
W 369	The system for dru that all drugs, inclu self-administered, a This STANDARD Based on observat review, the facility incree administered out error, for one of facility. (Client #3)  The finding include During Client #3's	g administration must assure ding those that are are administered without error. Is not met as evidenced by: ion, interview and record failed to ensure that medication if prescribed medication with fithe four client's residing in the assure that medication with the four client's residing in the assure that medication with the four client's residing in the assure that medication administration on	W:	369			
	The medication nu from the medication medications.  Review of the phys 2007 revealed that the following topics medication pass:  1) Erythromycin 2 area of beard BID 2) Laprox Shampo 3) Lachydron 12% the leg BID 4) Desonide 0.5% of face BID  However only the (the ear and neck a was applied to bot pass. After applying the discrete that the second pass. After applying the discrete that the second pass.	are approximately 7:52 PM, are was observed to remove in cabinet four topical sician's order dated August 1, 1 Client #3 was to have received at treatment during the evening % Solution Apply to affected to to scalp 2 X week a Lotion Apply to scaly areas of a cream Apply to affected area (1) Erythromycin 2% cream to and the (2) Amilactin 12 % lotion in lege during the medication and this medication, she stated all 4 medication back in set.			Refer to W 149 (3) P. 6 Refer to attachment #6 (b)	;	0-16-07

CENTE	<u>RS FOR MEDICARE</u>	AND HUMAN SERVICES & MEDICAID SERVICES			_	FORM	10/02/2007 APPROVED
AND PLAN C	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) A A. BU		IPLE CONSTRUCTION IG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		09G177	a. wi	NG_			C 2/2007
	ROVIDER OR SUPPLIER F WASHINGTON			2	REET ADDRESS, CITY, STATE, ZIP CODE 49 11TH STREET, SE VASHINGT()N, DC 20019	<u> </u>	22001
(X4) ID PREFIX TAG	LEAGH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	TX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPRIETY)	II D. EC.	(XS) COMPLETION DATE
W 369	Continued From pa	ge 19	W	369		<del></del>	
	nowever, revealed treatment medication follows:  1). Ketoconazole Crarea twice daily 2) Minerin Cream a moisturizer	for September 2007, that Client #3's topical ons for administration were as eam 2% apply to affected apply daily to skin for Cream Apply to dry area of		• 1			
	nurse did not coincinadministered the Arthe med pass, howelist on the physician Ketoconazote Crear administered twice of MAR revealed that the indicated that this madministered during ordered. 3. The Mir Cream which was pleas as ordered, 483.460(I)(1) DRUG RECORDKEEPING	the medication pass as term Cream and the Desonide rescribed for the PM had not either during the medication STORAGE AND re drugs under proper ion.	Wa	377	Refer to W 149 (3) P. 6 Refer to attachment #6 (b)	1	D-16-07
	Deser OH ODSERVANC	not met as evidenced by: In and interview the facility lication were stored under				·	

10/02/2007 04:41 FAX 202442943	10/02	2/2007	04:41	FAX	202442	9430
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DEPART CENTER	IMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES						10/02/2007 APPROVED
Statement	OF DEFICIENCIES	(X1) PROVIDENSUPPLIENCLIA	Over 10				OMB NO	0938-0391
AND PLAN O	F CORRECTION	DENTIFICATION NUMBER:	A. BU		IPLE CONSTRU VG	ICTION	(X3) DATE S COMPLI	
<u>L</u>		09G177	8, W()	NG_			1	C
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	PRET ADDRES	I, CITY, STATE, ZIP CO		<u>2/2007</u>
RCMO	WASHINGTON			( 2	249 11 TH STRI	ET, SE N, DC 20019	PE	
(X4) ID FREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PR(	MDER'S PLAN OF COR CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY	SHOULD BE	COMPLETION COMPLETION
W 377	Continued From pa	ge 20	187		<u> </u>	OCI INICIO I J	· · · · · · · · · · · · · · · · · · ·	<del> </del>
[	proper conditions o		w:	3//				
	The finding include:							
	The facility's medic	ation nurse failed to ensure		•		į.	•	
	medication adminis	ol practices during the stration in accordance with the						
<b>j</b>	agency's infection of as evidenced below	somborme has voiled leting						
					it is importar	nt to note that the fa	cility madication	
	1. On September 1	1, 2007 at approximately 6:22			nurse was te best practice	erminated for not usin	ng the nursing	
1	in the medication of	nurse was observed to reach oset and remove Client #4			,			}
	Glycolax and place	scoop in his water. The nurse arch for the top for the			All of agen the infection	cy's nurses have bee control according to	en inserviced on	
	mixture, nowever si	he was not able to find the top			procedures,			0-16-07
i	to secure the medic	cation from contamination.			Refer to atta In the future	the agnency's nursi	ng department	}
l i	medication cup loos	selv on too of the bottle and			will ennsure	that the infection con ented during the med	ntrol procedures	
	put the module bac	k into the medication closet. Ence that this medication was	-		are impleme	med during the med	ncauon pass.	
]	seal to ensure its co	ontinued potency.			]			
		cation pass on September 11,			1			
	ZUV/ at approximat	©V 6:55 PM the medication						
[ }	Murse was observed	to administer Client #3's edication cup. After the client						
<b>(</b>	m uran rayrau biz we	Cation he bessed the our by i			Pafar to W 1	149 (1) P. 4,5		
	place the diffy med!	The nurse was observed cine cup onto the stack of			Keler to W 1	149 (1) P. 4,5	.10	16-07
}	minsearciesu weak	cine cups. The nurse realized inlinating the medicine cups,						1
]	not outh temoned th	18 too cup she place on the						
	arick and thick it s	way. The falled to discard ated medicine cups but placed			1			
,,,	might back to the Wi	edication closet			1			
W 381	483.460(I)(1) DRUG RECORDKEEPING	STORAGE AND	Wa	81				
FORM CMS-25	57/02-89) Devilous Variana							1

CENTER	MENT OF HEALTH	I AND HUMAN SERVICES  & MEDICAID SERVICES			•		10/02/2007 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(CC3) M	וו תוו	PLE CONSTRUCTION		0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BU			(X3) DATE SU COMPLE	
		09G177	B. Wil	NG_			
NAME OF P	ROVIDER OR SUPPLIER		<u>L.</u>	STE	REET ADDREES, CITY, STATE, ZIP CODE	09/12	2/2007
RCMO	F WASHINGTON			) 2	49 11TH STREET, SE VASHINGT()N, DC 20019		
(X4) ID PREFIX PAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIPYING INFORMATION)	ID FREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS REFERENCED TO THE APPR DEFIGIENCY)	ULD AE	COMPLETION CATE
W 381	This STANDARD is Based on observat facility failed to stor conditions of secur. The finding include The facility failed to medications and to were secured in ac	ore drugs under proper ity. is not met as evidenced by: ion and staff interview, the e drugs under proper ity.	W	381			
	The medication numedication cabinet the bathroom. Clie the area when the unsecured.  2. During the medication numedication number 12, 200 The medication number at the composition of the collect the room for second topical medication for the collect the room for second topical medication for second topical	ication administration on 17 at approximately 6:22 PM, rse was observed to leave the open and unlocked to go into int #4 and the surveyor were in medication cabinet was cation administration on 17 at approximately 6:22 PM, rse was observed to leave dication for Client #3's omputer table unsecured and in the area when the it was unsecured.			Currently all medications are kept on cabined. All nurses were trained on the medication storage. Refer to attachment #9 Inthe future the nursing department with the medications are stored accordagency's policies and procedures.  Currently all medications are kept on a cabined. All nurses were trained on the medication storage. Refer to attachment #9 In the future the nursing department that the medications are stored accordagency's policies and procedures.	will ensure rding to the a locked be will ensure	0-16-07 10-16-07
	The medication nu	ication administration on 17 at approximately 6:22 PM, rse was observed to pour f Risperdal 1 mg pill in error					

if continuation sheet Page 23 of 24

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/02/2007 APPROVED 0938-0391
AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU(	TIPLE CONSTRUCTION	(X3) DATE S	IBVEV
		09G177	B. WING			C
NAME OF P	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<del></del>	TREET ADDRESS OFFI	09/1	2/2007
RCMO	F WASHINGTON		١	TREET ADDRESS, CITY, STATE, ZIP CODE 249 11TH STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PRIMOTER, DO 20019  PRIMOTERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPROPRIED TO THE APPROPRIED CY)	はなり PE	(XS) COMPLETION DATE
	nurse then place the shelf of the computer and half medication to leave the medical occasions without a medication. At not medication pass did to the computer table safety of the client at #4, direct care staff area when the medication in the medication.  The facility must keel locked except when administration.  This STANDARD is Eased on observation of the computer table unsertings and biological being prepared for a medication nurse Client #3's topical medication in the correction of the cor	the wrong medication". The e paper cup with the pill on the er table. Through-out the two expass the nurse was observed ation room on several ecuring this dosage of ime during or after the if the medication nurse return le to secure this pill for the and others. Client #3, Client and the surveyor were in the ilication was unsecured. Indeed that the nurse prepared and the surveyor alerted the er departure that she had left edication room on the ecured. Is STORAGE AND  appeared for  s not met as evidenced by: on, the facility failed to keep all is locked securely when not administration.  2007 at approximately 8:16 e was observed to leave edication for his skin inputer table unsupervised d went into the bathroom. The medication cabinet open	W 38	Refer to W 381 (1,2) P 22		0-16-07
	67(02-89) Previous Versions (		<del></del> -	Jilly ID, AAD, T		

Event ID: 6V2111

Facility ID: 09G 177

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			•	FORM	10/02/2007 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUITION	(X3) DATE SI COMPLE	0938-0391 IRVEY
		09G177	B. Wi	NG_			© 2/2007
	rovider or supplier F Washington			2	REET ADDRESS, CITY, STATE, ZIP CODE 249 11TH STREET, SE NASHINGTON, DC 20019	<u> </u>	2/200/
(X4) ID PRFFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PRC VIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-F, EFERENCED TO THE APP DEFICIENCY)	MIIDAE	(X5) COMPLETION DATE
/nt 2 <u>63</u>	medication in which was left on the com	30 and went into the client  n. Additionally, Client #4's  n she had punched in error  puter shelf unsupervised and  required by the agency's	W:	382			,
	There was no evide ensured the all the consistently and pro	ence that the medication nurse client's medications were openy secured.			Refer to W 381 (1,2) P 22	1	0-16-07
		·					
	: -						

STATE FORM

PRINTED:,10/02/2007 FORM APPROVED

	F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	IMBER:	A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE : COMPL	SURVEY EYED C
ALLE OF B	001000000000000000000000000000000000000	09G177		L	<del></del>	· •	C 12/2007
	ROVIDER OR SUPPLIER			DDRESS, CITY, S			12/2001
CMO	WASHINGTON		WASHIN	H STREET, SE IGTON, DC 20	: 019		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Atement of Deficiencie Y must be preceded by BC Identifying Inform	r Pin is n	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REPERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X6) COMPLE DATE
R 000	INITIAL COMMENT	TS		R 000			<del> </del>
	Client #1 that occur the group home in		oth of 1, 2007 in				
•	licensure deficience based on observation interviews with facili management and displayed medical records an	ation was initiated on 17 - September 12, 21 es cited in this report on of the medication lity direct care staff, rest day program staff, rest d review of habilitation the unusual incident	007. The twere nurse, view of				
R 125		UND CHECK REQU		1			
	contract worker for in all jurisdictions we employee or contract	round check shall dis ne prospective empk the previous seven ( ithin which the prosp ct worker has worke even (7) years prior t	Dyee or (7) years, ective			·	
	pased on the review failed to ensure crim disclosed the crimin employee or contrar seven (7) years, in a the prospective employee.	met as evidenced by w of records, the GHI ninal background che lal history of any process worker for the prevall jurisdictions within ployee or contract world in the seven (7) years.	MRP acks spective vious which				
	The finding includes	<b>3</b> ;					
	failed to provide evic	nnel records on Sep revealed that the Gi dence that ensured o	JMDD				
7 Pegy 2	tion Administration	. 0		·			<u>L</u> .

6V2111

NO PLAN	it of deficiencies of correction	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	A BUILDI		(X3) DATE SI COMPLE	TED
		09G177		B. WING	<del></del>	no.44	; 2/2007
NAME OF P	ROMDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET ADI	RESS, CITY	STATE, ZIP CLIDE		612UU I
	F WASHINGTON		249 11TH WASHING	STREET. 9	SE		
(X4) ID PREFIX TAG	I REALTH LICENCIPING Y	ITEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	C. L.	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY	ON SHOULD BE OF APPROPRIATE	COMPLETE DATE
R 125	Continued From pa	ge 1		R 125	-	·	<del></del>
	⊃laπ #∠ seven vear	were on file and dis history of all the juri e resided and has be	edictions		The background check for staff the corporate office, not a the Refer to attachment # 10 In the future the agency will er personal records are on files, a request.	facility,	9-25-07
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n Regula	ition Administration						